Dr. Dale Macdonald & Associates

ELITE SPORTPERFORMANCE

Comprehensive Patient Questionaire

Last Name: First Name: Initials: Age:

Street Address: DOB: / / dd mm yy

City: Province: Postal Code:

Home: ( ) Bus. ( ) Mobile: ( )

Email:

Marital Status: O Single O Married O Divorced O Common Law

First Name of Partner/Significant Other:

Children: O Y O N Ages & Sex:

Occupation: Place of Employment:

Emergency Contact: Phone: ( )

REFERRAL: O Self O Physician O Other:

Physician: Phone: ( )

Dentist: Phone: ( )

AHC #:

List any health professionals you currently see:		**Reason**
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	

Current health conditions you desire improvement in **and** length of time they have been a concern to you, placed in order of importance:

1.

2.

3.

4.

5.

6.

To what extent do these areas interfere with your daily activities (work, sleep, etc.)?

Have you been given a diagnosis for this problem -- if so, what?

Family History

Check the box if there is a family history for the following health problems. If the health condition resulted in a family member death, please mark the third column with DC.

Allergies/Hay Fever	○		
Alcoholism	○		
Anemia	○		
Arthritis	○		
Asthma	○		
Cancer	○		
Diabetes	○		
Digestive Illness	○		
Epilepsy	○		
Glaucoma	○		
Headaches	○		
Heart Disease	○		
High Cholesterol	○		
High Blood Pressure	○		
Kidney Disease	○		
Mental Illness	○		
Obesity	○		
Stroke	○		
Syphilis	○		
Thyroid Condition	○		
Tuberculosis	○		
Other	○		

Abbreviation LEGEND

MGM: maternal grand mother

PGM: paternal grand father

MGF: maternal grand father

PGF: paternal grand father

F: father

M: mother

B: brother

S: sister

Sp: spouse

C: children

DC: deceased

Past Medical

Hospitalization (year, reason):

Surgeries (year, reason):

Serious Illnesses/injuries/accidents (year, cause/injury):

Childhood Illnesses:

Health as a child (1: poor to 10: excellent): If less than 8, explain:

○ Rheumatic Fever ○ German Measles ○ Polio ○ Allergies ○ Chicken Pox

○ Frequent Colds/Flus ○ Mumps ○ Ear Infection ○ Skin Conditions (eczema,psoriasis)

Vacinations:

Type, year, adverse reactions:

Allergies: (list all known)

Allergy	Items	Reaction
Drugs		
Foods		
Other		

Pets:

What Kind	How Many

Medications:(prescription & over-the-counter)

Medications	Dose	How Long?	For What?

Supplements: (non-prescription, herbal, nutrional, any over-the-counter items)

Supplement	Dose	How Long?

Have you ever had general anesthetic? ○ Yes ○ No If yes, when? _____

Antibiotic Use? ○ Yes ○ No if yes, when? _____

Dental:
To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type), pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.

Date	Treatment

Describe any current dental concerns or symptoms:

Are you aware of any grinding of your teeth or clenching your jaw? ○ Yes ○ No

If yes, when? ○ day ○ night ○ both

Chemicals:
Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapors, dry cleaning agents

Item	When	How Long?	Work or Home

Travel: (list back country & third world trips)

Item	When	Illness or trauma

Lifestyle
Enjoy Work? ○ Yes ○ No If No Why?

What have been your previous occupations?

Please indicate on the line below where you feel your current balance between work and play is:

All Work 0 - - - - -1 - - - - -2 - - - - - 3 - - - - 4 - - - - - 5 - - - - - 6 - - - - - 7 - - - - - 8 - - - - - 9 - - - - 10 **All Play**

Physical Fitness
Exercise Regularily? ○ Yes ○ No Describe your program:

Hobbies
Please list your hobbies or recreational interests:

Support, Stressors & Personal Growth

Do you get along with your family? ○ Yes ○ No

Please list the stressors that affect you the most:	Please list the people/areas that support you the most:
1.	1.
2.	2.
3.	3.

Do you currently follow a (religious/spiritual) belief system?

Do you feel supported and comfortable with this belief system?

Do you: ○ Meditate ○ Pray ○ Use Visualization ○ Use Relaxation Techniques

○ Use other Techniques? Describe:

How might you finish this statement in regards to suggestions/programs for your health.....I:

○ can follow the plans/programs ○ start programs then let things slide

○ prefer choosing from options ○ am easily overwhelmed

How will you know when you are feeling better:

How might things look for you when your life is very good?

Do you have any concerns or reservations in pursuing complementary & alternative therapies?

Smoking:

	How Often	**How Long?**	**Quit - When**
Cigarettes			
Cigars			
Pipe			
Marijuana			

Drinking:

	How Often	**How Long?**	**Quit - When**
Liquor			
Beer			
Wine			
Coffee			
Soft Drinks			

Diet: (for each 'yes' list type, serving size & frequency)

	Yes	No	
Vegetarian	○	○	If yes, what kind? ○ Lacto ○ Ovo ○ Lacto-Ovo ○ Pesco ○ Vegan
Meat	○	○	
Fish	○	○	
Fowl	○	○	
Dairy	○	○	
Eggs	○	○	
Beans/Legumes	○	○	
Fruits	○	○	
Vegetables	○	○	
Grains/Bread/Pasta/Cereal	○	○	

Meal	**Time**	**Food/Drink**
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Drinks	N/A	
Cravings	N/A	
Aversions	N/A	

What kind of water do you drink and how much?

Please mention any foods or drinks that aggravate your symptoms or that you find hard to digest:

Diet Continued:

How long have you been following this diet?

Do you eat or use any of the following:

○ Margerine	○ Processed/Deli Meats	○ Alumninum Pots/Utensils	○ Lard
○ Sugar	○ Microwave	○ Crystal/Packaged Drinks	○ Candy
○ Shortening	○ Artificial Sweeteners	○ Fried Foods	

Part B - Review of Symptoms

Please complete the following section as thoroughly as you can. For every question that you answer "yes" or " past", please explain your answer further on the accompanying line.

General:

Weight		Height	
Weight 1 Year Ago		Date of Last Physical	
Maximum Weight		Date of Last Blood Work	
When			

Energy: 1 (poor) - 10 (great): _____ Does your energy vary within a day? ○ Yes ○ No

If Yes, circle & label the time(s) of day you feel is/are best (B) or (W) for you:

Midnight 1 2 3 4 5 6 7 8 9 10 11 noon 1 2 3 4 5 6 7 8 9 10 11 Midnight

What makes your energy better?

What makes your energy worse?

Sleep:

	Yes	No	Explanation
Sleep Well?	○	○	If No please specify
Insomnia	○	○	
Sleepy during the day?	○	○	
Wake up at night?	○	○	
Wake early in the morning?	○	○	
Restless?	○	○	
Nightmares/Dreams	○	○	
Wake to use washroom?	○	○	
Wake Rested?	○	○	If No please specify:
Grains/Bread/Pasta/Cereal	○	○	
Average Hours of Sleep per night			

Sweating:

	Yes	No	Past	Explanation
Night Sweats	○	○	○	
Perspire Profusely	○	○	○	
Perspire very little	○	○	○	
Do not perspire	○	○	○	
Sweat with high fever	○	○	○	

Skin:

	Yes	No	Past	Explanation
Eczema	○	○	○	
Psoriasis	○	○	○	
Rashes	○	○	○	
Hives	○	○	○	
Inflamation	○	○	○	
Infection	○	○	○	
Growths	○	○	○	
Changes in hair	○	○	○	
Change in nails	○	○	○	

Eyes:

	Yes	No	Past	Explanation
Glasses/Contacts	○	○	○	
Impaired Vision	○	○	○	
Eye Pain	○	○	○	
Tearing or or Dryness	○	○	○	
Red, Itching, Painful	○	○	○	
Double Vision	○	○	○	
Change in nails	○	○	○	

Ears:

	Yes	No	Past	Explanation
Hearing Loss	○	○	○	
Impaired Hearing	○	○	○	
Ringing	○	○	○	
Earache/Itch	○	○	○	

Nose & Sinuses:

	Yes	No	Past	Explanation
Frequent Colds/Year	○	○	○	
Nose Bleeds	○	○	○	
Stuffiness	○	○	○	
Sinus Problems	○	○	○	
Post Nasal Drip	○	○	○	

Mouth & Throat:

	Yes	No	Past	Explanation
Frequent Sore Throats	○	○	○	
Sore Tongue	○	○	○	
Sores in Mouth/On Lips	○	○	○	
Gum Problems/Bleeding	○	○	○	
Hoarseness	○	○	○	
Jaw Pain	○	○	○	
Dental Problems	○	○	○	

Respiratory/Chest:

	Yes	No	Past	Explanation
Cough	○	○	○	If Yes or Past: ○ dry ○ little phlegm ○ much phlegm
Wheezing	○	○	○	
Spitting up Blood	○	○	○	
Difficulty Breathing	○	○	○	
Pain on Breathing	○	○	○	
Shortness of Breath	○	○	○	
Shortness on Lying Down	○	○	○	
Shortness at Night	○	○	○	
Positive Tuberculosis Test	○	○	○	
Asthma	○	○	○	
Hay Fever	○	○	○	
Pain	○	○	○	If Yes or Past please describe: ○ sides ○ central chest ○ burning ○ prickling ○ distending ○ dull ○ other:

Heart:

	Yes	No	Past	Explanation
Chest Pain	○	○	○	If yes or past please describe below:
Is the pain... ○ burning ○ prickling ○ fullness ○ tightness ○ Distending ○ Dull ○ Other:				
Heart Disease	○	○	○	
High Blood Pressure	○	○	○	
Rheumatic Fever	○	○	○	
Swelling in Legs/Ankles	○	○	○	
Palpitation/Fluttering	○	○	○	

Digestion/Abdomen:

	Yes	No	Past	Explanation
Stomach/Abdominal Pain	○	○	○	If yes or past please describe below:
Is the pain... ○ cramping ○ prickling ○ fullness ○ Distending ○ Dull ○ Other: _____				
Pain is relieved by: ○ pressure ○ hot ○ cold ○ bowel movement				
Trouble Swallowing	○	○	○	
Heartburn	○	○	○	
Change in Thirst	○	○	○	
Do you prefer	○ hot	○ cold	○ not thirsty	
Change in appetite	○	○	○	If yes or past please describe below:
Describe the change as... ○ abnormal ○ overeating ○ under eating ○ hungry yet cannot eat				
Taste/Feeling in Mouth	○ bland	○ sour	○ salty	○ hot ○ sweet ○ bitter ○ sticky ○ metallic
Nausea	○	○	○	
Vomiting	○	○	○	
Belching/gas/bloating	○	○	○	
Do these symptoms occur... ○ during meals ○ 1 hour after meals ○ 2-3 hours after meals				
Heaviness from foods	○	○	○	
Liver/gall bladder disease	○	○	○	
Gall stones	○	○	○	
High Cholesterol	○	○	○	
Diabetes	○	○	○	
Mononucleosis	○	○	○	
Ulcers	○	○	○	
Pain before eating	○	○	○	
Pain after eating	○	○	○	
Low Blood Sugar/Hypoglycemia	○	○	○	
Irritable before meals	○	○	○	
Tired after eating	○	○	○	
Distress from fats/greasy foods (nausea, dizziness, headaches)	○	○	○	
Rapid Weight Change	○	○	○	
Hiccups	○	○	○	

Bowel Function:

Frequency of Bowel Movements	# times per ○ day ○ week			
Usual time of Bowel Movements				
Consistency of Bowel Movements				
	Yes	No	Past	Explanation
Diarrhea	○	○	○	
Constipation	○	○	○	
Alternate diarrhea & constipation	○	○	○	
Loose/Broken Stools	○	○	○	
Stool Hard to Pass	○	○	○	
Blood/Mucus in stools	○	○	○	
Undigested Food in Stool	○	○	○	

Urinary:

	Yes	No	Past	Explanation
Pain on Urination	○	○	○	
Burning on Urination	○	○	○	
Increase in Frequency	○	○	○	
Frequency at Night	○	○	○	
Change in Colour	○	○	○	
Change in Odor	○	○	○	
Unable to Hold Urine	○	○	○	
Incomplete Urination	○	○	○	
Bladder Infections	○	○	○	
Kidney Stones	○	○	○	

Circulation:

	Yes	No	Past	Explanation
Deep Leg Pain	○	○	○	
Cold Hands/Feet	○	○	○	
Varicose Veins	○	○	○	
Hemorrhoids	○	○	○	
Anemia	○	○	○	
Easy Bleeding/Bruising	○	○	○	

Neurological:

	Yes	No	Past	Explanation
Fainting	○	○	○	
Seizures	○	○	○	
Paralysis	○	○	○	
Muscle Weakness	○	○	○	
Memory Loss	○	○	○	

Sexual Function:

	Yes	No	Past	Explanation
Change in Libido	○	○	○	
Loss of Libido	○	○	○	
Infertility	○	○	○	
Veneral Disease	○	○	○	

Female Reproduction:

	Yes	No	Past	Explanation
Age Menses Began				
Date of Last Menstruation				
No. of days of Menstrual Flow				
Length of Complete Cycle				
Regular Self Breast Exam	○	○	○	
Date & Results of last PAP				
Abnormal PAP's	○	○	○	
No. of Pregnancies				
No. of Live Births				
No. of Miscarriages				
No. of Abortions				
Sexually Active?	○	○	○	
Birth Control	○	○	○	
Spotting Between Periods	○	○	○	
Are cycles regular?	○	○	○	If No, please describe: ○ early ○ delayed ○ irregular
Pain During Intercourse	○	○	○	
Cramps	○	○	○	
Abnormal Vaginal Discharge	○ yellow ○ white ○ thick ○ strong odor			
Vaginal Infections	○	○	○	
Menstrual Flow	○ normal ○ heavy ○ light			
Colour of Flow	○ normal ○ bright red ○ dark red ○ light red			
Consistency of Flow	○ thick ○ thin ○ clots			
PMS	○ breast tenderness ○ moods ○ water retention ○ headaches ○ craving ○ back ache ○ acne ○ bloating ○ other: _____			
Ovarian Cysts	○	○	○	
Uterine Fibroids	○	○	○	
Difficulty Concieving	○	○	○	
Menopausal Symptoms	○	○	○	

Male Reproduction:

	Yes	No	Past	Explanation
Date and results of most recent rectal exam for an enlarge prosteate exam.				
Impotence	○	○	○	
Premature Ejaculation	○	○	○	
Noctural Emissions	○	○	○	
Hernias	○	○	○	
Testicular Masses	○	○	○	
Testicular Pain	○	○	○	
Are you Sexually Active?	○	○	○	
Sexual Difficulties	○	○	○	
Any prostate problems?	○	○	○	
Discharge/Sores	○	○	○	

Difficulty starting/stopping urination	○	○	○	
Birth Control	○	○	○	

Risk of Infection:

	Yes	No	Details
HIV	○	○	
Hepatitis B	○	○	
Hepatitis C	○	○	

Emotional:

	Yes	No	Past	Explanation
Mood Swings	○	○	○	
Depression	○	○	○	
Anger/Resentment	○	○	○	
Anxiety/Nervousness	○	○	○	
Fear	○	○	○	
	○	○	○	
Apathy	○	○	○	

Musculoskeletal:

	Yes	No	Past	Explanation
Joint Pain/Stiffness	○	○	○	
Muscle Pain/Stiffness	○	○	○	
Muscle Spasms/Cramps	○	○	○	
Low Back Pain	○	○	○	
Numbness/Tingling	○	○	○	
Arthritis	○	○	○	
Broken Bones	○	○	○	

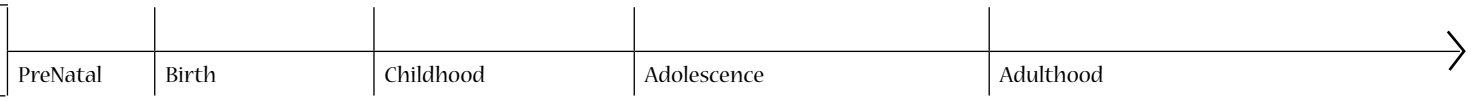
Miscellaneous:

	Yes	No	Past	Explanation
Thyroid Problems	○	○	○	
Heat Intolerance	○	○	○	
Cold Intolerance	○	○	○	
Fever	○	○	○	
Chills	○	○	○	
Alternating Chills & Fever	○	○	○	
Body Feels Cold	○	○	○	
Easy Weight Gain	○	○	○	
Rapid Weight Change	○	○	○	
Dizzy Upon Standing/Bending	○	○	○	
Fluoride Toothpaste	○	○	○	
Drink Tap Water	○	○	○	

Part C: STRESSORS & SYMPTOMS

Using the timeline below, list the ***stressors*** (surgery, accidents/injury, change in work/residence/relationships, births, loss, mental/emotional stress etc.) and ***symptoms*** (pain, digestive concerns, fatigue, headaches, allergies, menstrual changes, behavior/mood changes, etc.)

STRESSORS:



SYMPTOMS:

In the questionnaire that follows, read each statement and score it in the margin as follows:

- 0 - points if this statement is not true at or does not apply to you.
- 1 - point if the statement is true a lot of the time and/or is affecting the quality of your life.
- Please respond to all questions as though you were not taking any medications or supplements.

SECTION 1: Type - S

#	Question	Pts
1.	Do you have a tendancy to be negative or have dark pessimistic thoughts?	
2.	Are you often worried or anxious?	
3.	Do you have feelings of low self-esteem and/or lack of confidence?	
4.	Are you self-critical and feel guilty over small issues?	
5.	Do you have obsessive, repetitive, angry, useless thoughts that you are unable to turn off? Do they happen when you are trying to fall asleep?	
6.	Can your behaviour become obsessive? This can show up as difficulty making transitions, being inflexible, a perfectionist, controling? Computer, TV or work addict?	
7.	Do you suffer from seasonal affective disorder? Tend to get blue in the winter months? Symptoms of this are a tendancy to gain weight, fatigue, depression, and sleepig problems during the winter.	
8.	Are you apt to be irritalbe, impatient, edgy or angry?	
9.	Are you shy or fearful? Can you be nervous or panicky about heights, flying, enclosed spaces, public performances, bugs, crowds, leaving house etc.?	
10.	Do you have anxiety or panic attacks?	
11.	Do you suffer from PMS or menopausal moodiness (tears, anger and/or depression)?	
12.	Do you dislike hot weather?	
13.	Do you find it hard to get to sleep?	
14.	Do you wake up at night, have restless or light sleep, or wake to early in morning?	
15.	Do you find relief from the above symptoms through exercise?	
16.	Do you crave sweet or starchy snacks, wine, or marijuana in the afternoons, evenings or in the middle of the night?	
17.	Do you or have fibromyalgia, TMJ?	
18.	Have you had suicidal thoughts or plans?	
19.	Do you have gastrointestinal disorders such as irritable bowel, gas and/or bloating?	
20.	Do you suffer from general fatigue?	
	TOTAL	

SECTION 2: Type - D

#	Question	Pts
1.	Do you feel flat and bored a lot of the time?	
2.	Do you like to sleep more than normal and are slow to get out of bed?	
3.	Do you crave or use stimulants like coffee, recreational drugs, alcohol and chocolate, diet soda, ephedra and cocaine to get high?	
4.	Do you lack libido, a reduced sex drive?	
5.	Do you feel that you have reduced feelings of satisfaction, and assertiveness.	
6.	Has your short term memory, concentration and ability to learn changed for the worse?	
7.	Do you lack appetite?	
8.	Do you tend to have muscle stiffness?	
9.	Do you crave pleasurable experiences?	
10.	Have you been under a lot of stress in your life from traumatic experiences?	
11.	Do you get more accomplished under high stress environments?	
12.	Are you a procrastinator, waiting until the last minute to accomplish tasks?	
13.	Do you tend to be low on physical or mental energy?	
14.	Do you have to push yourself to exercise?	
15.	Is your drive, enthusiasm, and motivation on the low side?	
16.	Do you have difficulty focusing and concentrating?	
17.	Are you easily chilled, cold hands and feet?	
18.	Do you tend to put on weight easily?	
19.	Do you often wish that you were more alert and motivated?	
20.	Do you often have spontaneous muscle twitches, restless leg syndrome?	
	TOTAL	

SECTION 3: Type - T

#	Question	Pts
1.	Low energy and/or lethargy.	
2.	Require lots of sleep, and have trouble getting up in the morning.	
3.	Suffer from depression this may also include post partum.	
4.	A tendency to feel cold, especially in your hands and feet.	
5.	Poor concentration, mental sluggishness, and/or poor memory.	
6.	A family history of thyroid problems?	
7.	Weight gain that began with: The onset of menstruation, after a miscarriage, abortion, birth, and/or menopause.	
8.	Chubby or overweight since childhood.	
9.	Tendency to excessive weight gain or inability to lose weight despite normal eating.	
10.	Hoarseness and/or gravelly voice.	
11.	Low blood pressure, and/or hear rate.	
12.	Menstrual problems, excessive bleeding, severe cramping, irregular menses, PMS, scanty flow, late or early menarchy (before 12) premenopausal cessation of menstruation.	
13.	Reduced sex drive.	
14.	Swollen eyelids and face, general water retention.	
15.	Thinning or loss of outside eyebrow hair.	

16.	Tendency to have low blood pressure.	
17.	Headaches (including migraines)	
18.	High cholesterol, atherosclerosis, and/or high homocysteine.	
19.	Lump in throat and/or trouble swallowing pills.	
20.	Slow body movement or speech.	
21.	Change in hair or skin (thinning/loss/ dryness)	
22.	Weak brittle nails	
23.	Constipation	
24.	Tight tendons, muscle stiffness/ tension.	
	TOTAL	

SECTION 4: Type - A

#	Question	Pts
1.	Do you often feel overworked, pressured or dead-lined?	
2.	Trouble relaxing, or loosening up	
3.	Body tending to be stiff, uptight, tense?	
4.	Easily upset, frustrated, or snappy under stress?	
5.	Often feel overwhelmed or as though you just cant get it all done?	
6.	Weak, shaky at times?	
7.	Sensitive to bright light, noise, or chemical fumes? Need to wear dark glasses?	
8.	Feel significantly worse if you skip meals or go too long without eating?	
9.	Use drugs or food to relax and calm down?	
10.	Have type II diabetes, hypoglycemia?	
11.	Tend to gain weight around the middle?	
12.	Do you dislike hot weather?	
13.	Reduced sex drive.	
14.	Chronically fatigued: a tiredness that is not usually relieved by sleep?	
15.	Feeling unwell a lot of the time, tend to have colds and flu's that hang on?	
16.	Decreased tolerance to cold, feeling cold a lot?	
17.	Small irregular brown spots have appeared on skin?	
18.	Hands and legs get restless-experience meaningless body movements?	
19.	Often become hungry, confused, shaky, or somewhat paralyzed under stress?	
20.	Water retention, bloating, digestive problems?	
21.	Feeling "wired" yet "tired at the same time.	
	TOTAL	

Declaration and Informed Consent to treatment:

This form is designed to present benefits and risks of the therapies offered by Dr. Eric Arrata, ND and must be signed before treatment is rendered. Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.

Treatments may include one or a combination of the following:

- Dietary and nutritional counselling
- Nutritional and other supplementations, either orally, topically or as injection/IV therapy such as vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, homotoxicological preparations and others.
- Nutritional or other IV therapy, chelation (detox) therapy, and more.
- Injection therapies (neural therapy, prolotherapy, trigger point & neuralprolotherapy and more)
- Counselling & Energy therapies.

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding.

I am seeking medical health care services, including alternative medical therapies with Dr. Eric Arrata. I hereby request and consent to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, and botanical medicines) on me (or on the patient named, for whom I am legally responsible) by Dr. Eric Arrata.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Physician in Alberta has limitations including at this time no prescription privileges and lack of hospital privileges. Consequently, a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest.

I understand that this medical practice uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine.

I understand that it is not recommended that any medical test be purchased without a medical consultation. If I purchase a medical test without a consultation it is done so at my own risk.

I understand that I am in no way obligated to purchase the products or run labs recommended by Dr. Eric Arrata. I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, in the practice of Naturopathic medicine, in the practice of intravenous therapy, in the practice of nutritional and other supplementation, in the practice of hormone therapy, in the practice of any treatment we administer or order there are some risks.

These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from intra-muscular injections, venipuncture or acupuncture.

Below is a more in-depth explanation of some of the various therapeutic modalities used by Dr. Eric Arrata.
A Naturopathic physician is trained as a general family practitioner. Naturopathic physicians combine modern laboratory and physical diagnostic tools with natural, nontoxic therapies that encourage the body's inherent healing abilities. Some of the treatments may include nutrition, herbal medicine, homeopathy, counselling, physiotherapy, hormone replacement therapy, hormone reduction therapy, electrotherapy, natural supplementation and other natural remedies.
Nutritional and herbal supplements. At times, your organ systems and tissues may need nutritional and/or herbal support. Make sure to tell your doctor about any medications you are currently taking so that drug/herb/supplement interactions are minimized. Potential side effects of any herb/supplement recommended to you will be discussed your doctor.

All Medical Tests, supplements, and consults are non-refundable. At the discretion of the doctor labs that have not been completed may be returned with a 25% discount from the cost of the lab. All supplements are non-returnable.

All clients must give 48 hours' notice for cancelled appointments. Missed appointments will be billed to the client at 100% the cost of the visit.

Patient's Full name (please print): _____
First Middle Last

Date of Consent: _____
Day Month Year

X_____
Signature of Patient (or legal guardian)